DESCRIPTION OF MENTAL EMOTIONAL, NERVOUS DISORDERS

OR CHEMICAL DEPENDENCY

Name: _____
(Last) (First) (Middle)

SSN: _____

DATE OF TREATMENT: From: _____ To: _____

NAME OF TREATING PROFESSIONAL: _____

Street: _____
City: _____ State: _____ Zip _____
Telephone: _____

NAME OF HOSPITAL OR INSTITUTION: _____

Street: _____
City: _____ State: _____ Zip _____
Telephone: _____

Describe completely your diagnosis and treatment: